

The Patient-Centered Medical Home: An Essential Destination on the Road to Reform

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In recent years, the patient-centered medical home (PCMH)—often referred to in its abbreviated form, the “medical home”—care delivery model has become one of the hottest topics in healthcare. Based on a holistic, patient-centric approach, the PCMH represents a methodology aimed at fostering increased collaboration among healthcare stakeholders. As such, the PCMH is widely believed to offer perhaps the best hope to transform and improve the system as a whole.

For example, Geisinger Health System reduced hospital readmissions by 18% through its medical home program and by 44% with its ProvenCare one-price elective cardiac surgery medical home program.¹ Paul Grundy, MD, MPH, Global Director of Healthcare Transformation for IBM and Chairman of the Patient-Centered Primary Care Collaborative, recently stated in his keynote presentation of the Medical Home Summit in Philadelphia that his review of evidence from ongoing PCMH pilots has resulted in a 9.6% overall reduction in costs.²

To a certain degree, the PCMH is a reversal of the longstanding episode-based methodology that has been prevalent in healthcare for many years. Unlike the episodic-based care, the PCMH encourages patients and their providers to work closely together to ensure that care is more comprehensive, coordinated, and consistent. In essence, the medical home necessitates an ongoing, full-spectrum approach to patient care that requires the primary healthcare provider and the patients themselves to maintain complete awareness of the patients and their specific healthcare needs and experiences. This approach should result in more streamlined and appropriate care, reduced waste, lower costs and, most important, better outcomes.

Although the PCMH model had already been building momentum on its own, interest in this concept skyrocketed after it received a significant endorsement in the Patient Protection and Affordable Care Act (ACA) of 2010. That legislation strongly encourages the proliferation of medical homes and accountable care organizations (ACOs) as innovative means of delivering and reimbursing for better coordinated and cost-effective care.



The Patient-Centered Primary Care Collaborative (PCPCC.net) is an organization with the goals of facilitating improvements in patient-physician relations, and creating a more effective and efficient model of healthcare delivery. They have created a stakeholder group charged with showing that the PCMH provides the foundation for successful implementation of the ACO delivery model.

Moving patients through the ACO will require a strong element of care coordination, so we look forward to seeing the results of this group.

ACOs and the Patient-Centered Medical Home

An ACO is a business and a medical entity that accepts responsibility for the cost and the quality of care provided to a given population of patients and generates the data on their performance. This includes physician practices and may include hospitals, nursing homes, home health agencies, and other provider organizations.

The ACO model is called out specifically within the ACA as a preferred solution for bending the healthcare cost curve, while improving patient outcomes. There is funding within the bill to implement ACOs for Medicare and Medicaid,³ and the criteria have already been determined for ACOs to become involved with both programs. Because the PCMH will provide the care coordination that is required to make the ACO model work, most ACOs will likely take root in areas that have a sufficient number of medical homes.

The Benefits to Patients and Providers

In addition to the system-wide improvements it is expected to foster, the PCMH can also offer distinct sets of benefits for healthcare's primary stakeholders—patients, providers, and health plans. In a medical home structure, the patient is aligned with a care coordinator (normally a registered nurse, physician assistant, or social worker) at the provider practice level whose primary function is to manage the patient's health across the care spectrum.

The care coordinator interfaces on the patient's behalf with the health plan, specialists, pharmacists, labs, and other stakeholders to formulate a more efficient

and holistic approach to treatment. This generally results in a more informed and engaged patient—one who, through the care coordinator, has a more simplified access to care, better understands his or her own needs, and is more likely to comply with treatment recommendations and suggested preventive measures.

For providers, the PCMH fosters an environment of transparent reporting on progress toward measurable outcomes that could potentially result in certain medical home incentives and bonus payments. Such additional reimbursement to the family physician also provides a benefit to society as a whole, because it addresses the primary care shortage that is predicted to occur if current trends in healthcare continue. This is important, because primary care is the foundation of the healthcare system. In areas where primary care is strong, patients have better outcomes and are more satisfied, while health disparities and healthcare costs are lower.⁴

In addition, with the ability to outsource aspects of care coordination to the health plan or to other entities, the provider can simultaneously maximize outcomes. That is, by reducing or eliminating certain associated administrative functions, clinical practices can manage more patients, at a lower cost.

Health plans generally maintain the most comprehensive clinical data available for their individual members. In the medical home, they provide this information to provider practices electronically and establish bonus and incentive structures for relevant outcomes. Providers, in turn, can plan and manage related activities to maximize the benefits.

The Benefits to Health Plans

For health plans, the medical home model can offer distinct competitive advantages in a number of key areas, including:

- *Reduced costs and improved health outcomes.* Although this value proposition has yet to be fully tested, the PCMH model is the most promising way of significantly enhancing the efficiency and cost-effectiveness of care management.
- *Clinical relevance.* A health plan adds value to the care management process with its rich patient data and expertise. Its willingness to collaborate with customers is attractive to employers investigating the PCMH as a means of keeping their workforce productive, and to providers making this paradigm shift.
- *Member satisfaction and retention.* Members whose health is managed within the medical home structure generally report greater overall satisfaction. This becomes a significant factor under healthcare reform, wherein members will have a greater opportunity to switch between health plans.

- *Provider satisfaction.* Early physician satisfaction scores show that primary care physicians derive greater satisfaction within the PCMH model compared with the existing fee-for-service approach. For example, Group Health of Puget Sound reported after implementation of the PCMH model, “less staff burnout, with only 10% of pilot clinic staff reporting high emotional exhaustion at 12 months compared to 30% of staff at control clinics, and, major improvement in recruitment and retention of primary care physicians.”⁵ Therefore, the medical home creates an opportunity for payers to strengthen relationships with provider networks, by offering systems and reimbursement frameworks that support care coordination and a team-based approach.
- *Improved care collaboration.* By fostering an environment of patient-centric activity closer to the patient and leveraging the relationship patients have with their primary care physician, care management administration and oversight are shifted to the point of care. With the right tools in place, the payer remains connected.

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Technology Key to Success of the Medical Home

The PCMH model is heavily predicated on the effective use of technology, which is clearly outlined in the healthcare reform law. Technology is the most promising means of enabling the very collaboration among healthcare stakeholders that is the foundation for the medical home concept itself. In particular, analytics technology—especially that which is focused on optimizing care management and quality reporting—will be key to the success of the medical home approach and to optimizing health outcomes.

Technology will enable medical home participants to receive patient data that have been analyzed and to identify factors such as gaps in care and medication adherence. This more inclusive, 360-degree view of the patient’s information that spans the full continuum of care, regardless of where the patient is seen, will enable more focused plans of care.

An example of this involves the integration of pharmacy services as part of the medical home, which is a

critical aspect of care when managing patients with many conditions who have received prescriptions from multiple physicians. The American College of Clinical Pharmacy has stated in its 2009 report, *Integration of Pharmacists' Clinical Services in the Patient-Centered Primary Care Medical Home*, that "Over the last decade, the clinical consequences and economic costs of medication misuse, and medication-related problems, including patient non-adherence and suboptimal therapeutic outcomes, have become more fully recognized by clinicians, policymakers, and health care economists."⁶ Inclusion of the pharmacist within the medical home workflow is a necessary first step in alleviating these issues by improved care coordination.

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The effective deployment of technical solutions can enable any physician practice, regardless of its size or its patient population, to successfully participate in a medical home model by establishing what, in essence, is a virtual medical home. Within this environment, the physician practice will be able to electronically connect with the health plan and other outside resources to deliver the same advantages of a "true" medical home, but with significantly less financial investment and administrative overhead. This is the result of allowing smaller physician practices to use resources as needed

rather than being required to maintain high numbers of full-time staff to provide a full range of services.

A Rare Opportunity

With the PCMH, the healthcare reform law may indeed be on to something—a rare instance in which each healthcare stakeholder stands to gain a lot, while sacrificing or compromising little. A number of test programs and pilots to date have generated favorable returns.⁵ Naturally, not all have been without their share of obstacles, and countless lessons have been learned, but evidence is mounting to indicate that the medical home, in practice, can deliver what many people have believed it can, in theory.⁵ If the tenets and mandates of reform are to take hold and achieve their true potential, the PCMH will undoubtedly play a significant role in making it happen. ■

Author Disclosure Statement

Mr Adamson reported no conflicts of interest.

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